

- (ii) Water Supply Scheme for arsenic affected areas of Murshidabad and Nadiad districts. A joint Action Plan with UNICEF has been taken up by the State Government for quick identification of arsenic affected sources, provision of arsenic Removal Units and capacity building for community management of such Units.

Government of India has so far sanctioned four Water Supply Schemes under arsenic sub Mission with 75 : 25 financial participation between Government of India and State Government.

The financial assistance from Government of India is in addition to Central Assistance for normal Water Supply programmes.

#### **Violation of Drugs and Cosmetics Act**

1532. SHRI KHAN GHUFRAN ZAHIDI: Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) whether the supply of products to World Bank assisted tender for TB are tested at NIPER for quality;

(b) whether it is a fact that the supplies are made without batch numbers in violation of Drugs and Cosmetics Act; and

(c) if so, the action being taken against the suppliers violating the Act?

THE MINISTER OF STATE IN THE MINISTRY OF HEALTH AND FAMILY WELFARE (SHRI A. RAJA): (a) No, Sir.

(b) As per the technical specifications prescribed for anti TB drugs in accordance with the provisions of the Drugs and Cosmetics Act, it is mandatory to indicate batch numbers; date of manufacturing and date of expiry of the blisters or packages. Supply of drugs are made directly from manufacturer to project districts/GMSDs. No complaint regarding batch numbers of supplies has been reported from any of the project districts or GMSDs.

(c) Not applicable.

#### **Malnutrition among Indian children**

1533.DR. KARAN SINGH:

SHRI C. M. IBRAHIM:

Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) whether malnutrition among Indian children, who constitute 38 per

cent of India's population is, to say the least, endemic and whether at least 53 per cent of the children are severely malnourished;

(b) if so, the percentage of malnourished children according to the three indices of malnutritional status, namely, weight for age, height for age and weight for height; and

(c) the targets for curbing and minimizing malnutrition under the Ninth Five Year Plan and those proposed or projected for the Tenth Five Year Plan in terms of numbers and percentages?

**THE MINISTER OF STATE IN THE MINISTRY OF HEALTH AND FAMILY WELFARE (SHRI A. RAJA):** (a) and (b) According to the National Family Health Survey (NFHS), 1998-99, the percentage of severely malnourished children is 18.0 while the percentage of severely malnourished children according to the three indices of malnutrition are as follows:—

Weight for age	18.0
Height for age	23.0
Weight for height	02.8

(c) The Ninth Plan aims and objectives and proposal for the 10th Plan are at Statement

#### **Statement**

The Ninth Plan aims to achieve the following objectives:

1. Freedom from hunger through increase in food production, effective distribution, improvement in purchasing power of the population.

2. Reduction in undernutrition and its health consequences through.

(a) Universalisation of Integrated Child Development Services (ICDS).

(b) Screening at risk groups.

(c) Growth monitoring.

(d) Targeting of food supplement to those suffering from under-nutrition.

(e) Close monitoring of under-nourished persons receiving food supplements.

(f) Effective intersectoral coordination between health and nutrition workers to ensure early detection and management of health problems associated with or leading to under-nutrition.

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3. Prevention, early detection and effective management of micro-nutrient deficiencies and the associated health hazards.

As a Tenth Plan strategy, efforts have to be made to move from untargeted food supplementation to fully operationalising growth monitoring, in order to identify onset undernutrition and initiate appropriate health and nutritional interventions. Another necessary step is to move from treatment of infection when children are brought to the health care centre in prevention, early detection and management of infections through improved access to health care.

**Disease pattern of the population of the country**

1534. SHRI MANOJ BHATTACHARYA: Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) whether the disease pattern of the population of the country is ascertained objectively; and

(b) if so, the details of the regional variations?

THE MINISTER OF STATE IN THE MINISTRY OF HEALTH AND FAMILY WELFARE (SHRI A. RAJA): (a) and (b) Yes, Sir. Disease pattern is ascertained objectively through collection of data from extensive studies, surveys nation-wide sentinel surveillance for HIV, disease surveillance programme for communicable diseases and also through various disease control programmes.

Keeping in view the epidemiological situation and pattern of Central assistance under the programme, the country is divided into three major divisions for assessing the malaria situation. North-Eastern States (100% Central assistance) contribute to 10% of malaria cases. Selected tribal predominant States viz., Andhra Pradesh, Jharkhand, Gujarat, Madhya Pradesh, Chhattisgarh, Maharashtra, Rajasthan and Orissa (which receive additional inputs in 100 selected districts under EMCP) contribute 67% and the remaining country (where 50% Central assistance is given) account for the balance, 23%. The prevalence of leprosy is high in Bihar, Jharkhand, Chhattisgarh, U.P., Orissa, West Bengal and low in North-Eastern States including Sikkim, Haryana, Himachal Pradesh, Punjab, Jammu and Kashmir, Rajasthan, Gujarat, Kerala and Karnataka. This disease is found to have moderate prevalence in Madhya Pradesh, Andhra Pradesh, Tamil Nadu and Maharashtra. The pattern of HIV is heterogeneous in the country. Based on nation-wide sentinel surveillance, HIV has been grouped in three categories. Group I is where HIV